~~APPROVED~~ DRAFT PA Criteria

Initial Approval: April 11, 2018
Revised Dates: April 10, 2019

CRITERIA FOR PRIOR AUTHORIZATION

Anti-emetics: Neurokinin 1 (NK-1) Antagonists/NK-1 Antagonist Combinations

PROVIDER GROUP Pharmacy
Professional

MANUAL GUIDELINES All dosage forms of the following drugs require prior authorization:
Aprepitant (Emend® oral, Cinvanti™)
Fosaprepitant (Emend® IV)
Fosnetupitant/palonosetron (Akynzeo® IV)
Netupitant/palonosetron (Akynzeo® oral)
Rolapitant (Varubi®)

*** This criteria combines and supersedes all previously approved criteria for the above listed products***

CRITERIA FOR PRIOR AUTHORIZATION FOR PREVENTION OF NAUSEA/VOMITING ASSOCIATED WITH CHEMOTHERAPY: (must meet all of the following)

- Patient must have a diagnosis of cancer
- Patient must be on oral or intravenous (IV) chemotherapy

LENGTH OF APPROVAL (INITIAL AND RENEWAL): 12 months

CRITERIA FOR PRIOR AUTHORIZATION FOR PREVENTION OF POSTOPERATIVE NAUSEA/VOMITING: (must meet all of the following)

- Request must be for oral aprepitant (Emend®)
- Must be used for prevention of postoperative nausea and vomiting (PONV)
- MUST NOT be used for treatment of PONV

LENGTH OF APPROVAL: 1 capsule for 1 fill

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR

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PHARMACY PROGRAM MANAGER
DIVISION OF HEALTH CARE FINANCE
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

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